Complete Summary

GUIDELINE TITLE

Hospital stay for healthy term newborns.

BIBLIOGRAPHIC SOURCE(S)

Miller C, American Academy of Pediatrics Committee on Fetus and Newborn. Hospital stay for healthy term newborns. Pediatrics 2004 May;113(5):1434-6. [28 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

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SCOPE

DISEASE/CONDITION(S)

General health

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide recommendations regarding the minimum criteria to be met before any newborn discharge

TARGET POPULATION

Healthy term newborns and their mothers

INTERVENTIONS AND PRACTICES CONSIDERED

1. Thorough evaluation of the infant, including physical examination, vital signs, and making sure that the infant has urinated and passed at least one stool spontaneously and has completed at least two successful feedings and that no abnormalities requiring continued hospitalization have been revealed
2. Educating the mother regarding breastfeeding and bottle feeding; appropriate urination and defecation frequency for the infant; cord, skin, and genital care for infant; ability to recognize illness and common infant problems; and proper infant safety
3. Maternal and infant blood tests
4. Initial hepatitis B vaccine
5. Hearing screening
6. Assessment of social risk factors
7. Assessment of parents regarding barriers to adequate follow-up care for the newborn
8. Continuing medical care for the mother and the infant

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

It is recommended that the following minimum criteria be met before any newborn discharge. It is unlikely that fulfillment of these criteria and conditions can be accomplished in less than 48 hours. If discharge is considered before 48 hours, it should be limited to infants who are of singleton birth between 38 and 42 weeks' gestation, who are of birth weight appropriate for gestational age, and who meet other discharge criteria as follows:

1. The antepartum, intrapartum, and postpartum courses for mother and infant are uncomplicated.
2. Delivery is vaginal.
3. The infant's vital signs are documented as being within normal ranges and stable for the last 12 hours preceding discharge, including a respiratory rate below 60 per minute, a heart rate of 100 to 160 beats per minute (Southall et al, 1980), and axillary temperature of 36.5 to 37.4 degrees C (97.7 to 99.3 degrees F) (Eoff, Meier, & Miller, 1974; Mayfield et al., 1984), measured properly in an open crib with appropriate clothing.
4. The infant has urinated and passed at least one stool spontaneously.
5. The infant has completed at least 2 successful feedings, with documentation that the infant is able to coordinate sucking, swallowing, and breathing while feeding.
6. Physical examination reveals no abnormalities that require continued hospitalization.
7. There is no evidence of excessive bleeding at the circumcision site for at least 2 hours.
8. The clinical significance of jaundice, if present before discharge, has been determined, and appropriate management and/or follow-up plans have been put in place (Bhutani, Johnson, & Sivieri, 1999; "Neonatal jaundice," 2001).
9. The mother's knowledge, ability, and confidence to provide adequate care for her infant are documented by the fact that she has received training and demonstrated competency regarding:
    - Breastfeeding or bottle feeding (the breastfeeding mother and infant should be assessed by trained staff regarding breastfeeding position, latch-on, and adequacy of swallowing)
    - Appropriate urination and defecation frequency for the infant
    - Cord, skin, and genital care for infant
    - Ability to recognize signs of illness and common infant problems, particularly jaundice
    - Proper infant safety (e.g., proper use of a car safety seat and supine positioning for sleeping)
10. Family members or other support persons, including health care professionals such as the family pediatrician or his or her designees, who are familiar with newborn care and knowledgeable about lactation and the recognition of jaundice and dehydration are available to the mother and her infant after discharge.
11. Maternal and infant blood test results are available and have been reviewed, including:

- Maternal syphilis and hepatitis B surface antigen status
- Cord or infant blood-type and direct Coombs test results, as clinically indicated ("Neonatal jaundice," 2001).
- Screening tests performed in accordance with state regulations, including screening for human immunodeficiency virus infection ("Human immunodeficiency virus screening," 1999).

12. Initial hepatitis B vaccine is administered as indicated by the infant's risk status and according to the current immunization schedule ("Recommended childhood and adolescent immunization schedule," 2004).
13. Hearing screening has been completed per hospital protocol and state regulations (Erenberg et al., 1999).
14. Family, environmental, and social risk factors have been assessed. These risk factors may include but are not limited to:
    - Untreated parental substance abuse or positive urine toxicology results in the mother or newborn
    - History of child abuse or neglect
    - Mental illness in a parent who is in the home
    - Lack of social support, particularly for single, first-time mothers
    - No fixed home
    - History of untreated domestic violence, particularly during this pregnancy
    - Adolescent mother, particularly if other conditions above apply

    When these or other risk factors are identified, discharge should be delayed until they are resolved or a plan to safeguard the infant is in place.

15. Barriers to adequate follow-up care for the newborn such as lack of transportation to medical care services, lack of easy access to telephone communication, and non–English-speaking parents have been assessed and, wherever possible, assistance has been given the family to make suitable arrangements to address them.
16. A physician-directed source of continuing medical care for the mother and the infant is identified. For newborns discharged less than 48 hours after delivery, a definitive appointment has been made for the infant to be examined within 48 hours of discharge. It is essential that all infants having a short hospital stay be examined by experienced health care professionals. If this cannot be ensured, discharge should be deferred until a mechanism for follow-up evaluation is identified. The follow-up visit can take place in a home or clinic setting as long as the health care professionals examining the infant are competent in newborn assessment and the results of the follow-up visit are reported to the infant's physician or his or her designees on the day of the visit (Nelson, 1999; Escobar et al., 2001).

    The purpose of the follow-up visit is to:

    - Weigh the infant; assess the infant's general health, hydration, and degree of jaundice; identify any new problems; review feeding pattern and technique, including observation of breastfeeding for adequacy of position, latch-on, and swallowing; and obtain historical evidence of adequate urination and defecation patterns for the infant
    - Assess quality of mother-infant interaction and details of infant behavior

- Reinforce maternal or family education in infant care, particularly regarding infant feeding
- Review the outstanding results of laboratory tests performed before discharge
- Perform screening tests in accordance with state regulations and other tests that are clinically indicated, such as serum bilirubin
- Verify the plan for health care maintenance, including a method for obtaining emergency services, preventive care and immunizations, periodic evaluations and physical examinations, and necessary screenings

The follow-up visit should be considered an independent service to be reimbursed as a separate package and not as part of a global fee for maternity-newborn labor and delivery services.

The fact that a short hospital stay (<48 hours after birth) for term healthy infants can be accomplished does not mean that it is appropriate for every mother and infant. Each mother-infant dyad should be evaluated individually to determine the optimal time of discharge. The timing of discharge should be the decision of the physician caring for the infant and should not be based on arbitrary policy established by third-party payers.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate decisions regarding the length of hospital stays for newborns and their mothers

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Local institution of these guidelines is best accomplished through the collaborative efforts of all parties concerned. Institutions should develop guidelines through their professional staff in collaboration with appropriate community agencies, including third-party payers, to establish hospital-stay programs for healthy term infants that implement these recommendations. State and local public health agencies also should be involved in the oversight of existing hospital-stay programs for quality assurance and monitoring. Additional research results from the Pediatric Research in Office Settings network study of the various issues of care of newborns and their mothers in the early postnatal weeks, including postdischarge follow-up, are anticipated to provide additional understanding of safe and appropriate practices.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 May

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics

GUIDELINE COMMITTEE

Committee on Fetus and Newborn

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee on Fetus and Newborn, 2002-2003: Lillian R. Blackmon, MD, *Chairperson*; Daniel G. Batton, MD; Edward F. Bell, MD; William A. Engle, MD; William P. Kanto, Jr., MD; Gilbert I. Martin, MD; Warren Rosenfeld, MD; Ann Stark, MD; *Carol Miller, MD (Past Committee Member)

Liaisons: Keith J. Barrington, MD, Canadian Paediatric Society; Jenny Ecord, MS, RNC, NNP, PNP, American Nurses Association, Association of Women's Health, Obstetric, and Neonatal Nurses, National Association of Neonatal Nurses; Solomon Iyasu, MBBS, MPH, Centers for Disease Control and Prevention; Laura E. Riley, MD, American College of Obstetricians and Gynecologists; Linda L. Wright, MD, National Institutes of Health

Staff: Jim Couto, MA

*Lead author

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatrics (AAP) Web site.

Print copies: Available from American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 2, 2004. The information was verified by the guideline developer on August 4, 2004.

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DISCLAIMER

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